

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03085

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3yrs. 10mo. 11days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Perry Point Veterans Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Barbara Unger Austin				4. DATE OF DEATH Month 3 Day 6 Year 1962													
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-72		9. AGE (In years last birthday) 90 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States									
13. FATHER'S NAME Mr. Charles Unger				14. MOTHER'S MAIDEN NAME Mario Deis													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Spanish American War				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH, Perry Point, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary infarcts right lung 4-50 </td> <td style="width: 10%;"> DUE TO </td> <td style="width: 60%;"> Interval BETWEEN ONSET AND DEATH 4-5 days </td> </tr> <tr> <td> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> (b) Bronchopneumonia bilateral severe </td> <td> 6-10 days </td> </tr> <tr> <td></td> <td> (c) Arteriosclerosis generalized </td> <td> unknown </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary infarcts right lung 4-50	DUE TO	Interval BETWEEN ONSET AND DEATH 4-5 days	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Bronchopneumonia bilateral severe	6-10 days		(c) Arteriosclerosis generalized	unknown	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary infarcts right lung 4-50	DUE TO	Interval BETWEEN ONSET AND DEATH 4-5 days															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Bronchopneumonia bilateral severe	6-10 days															
	(c) Arteriosclerosis generalized	unknown															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that XXXXXX XXXXXX attended the deceased from April 23, 1958, to March 6, 1962 and that death occurred at 3:20pm from the causes and on the date stated above.																	
22a. SIGNATURE A. L. Mooney				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-7-62											
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY				22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/62		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill		23d. LOCATION (City, town or county) (State) Elkton, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Hicks Funeral Home, Elkton, Maryland				25a. REC'D BY REGISTRAR DATE MAR 14 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna											

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Cumberland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shippensburg					
c. LENGTH OF STAY in 1b 10yrs6mo,15days						d. STREET ADDRESS 117 N. Penn Street					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First LYDA Middle J. Last BAILY						4. DATE OF DEATH Month March Day 14 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-87		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME H. H. Hyland						14. MOTHER'S MAIDEN NAME Susan A. Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I						16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelitis, acute, bilateral											
600.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (b) DUE TO											
(c), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with decompensation											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that XXXXXX attended the deceased from August 27, 1951, to March 14, 1962, and that death occurred at 8:50am from the causes and on the date stated above.											
22a. SIGNATURE S. Goldgraben						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 3-14-62		
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN Chief, Medical Service, VAH, Perry Point, Md.						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-17-1962		23c. NAME OF CEMETERY OR CREMATORY Unionville		23d. LOCATION (City, town or county) Kennett Square, Pa.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE LEE A. PATTERSON & SON, Perryville, Md.						25a. REC'D BY REGISTRAR DATE MAR 16 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



1934

April

03082

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Continued

10-27-34

Army Post

Western Washington Hospital

110 W. 1st St.

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H. E. Jones

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1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY in b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS R.D.1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Butler Toni Marie Butler First Middle Last 4. DATE OF DEATH March, 28 19 62 Month Day Year				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 25, 1962 9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Walter E. Butler 14. MOTHER'S MAIDEN NAME Marguerite Russell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Walter E. Butler, Elkton, Md. R.D.1 Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Aspiration of Vomitus (c) 10 minutes INTERVAL BETWEEN ONSET AND DEATH 10 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) None				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Spontaneous vomiting after given vitamin drops & aspiration of same (Accident)				20c. TIME OF INJURY Month, Day, Year Mar. 28 62 Hour a.m. ----- 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Elkton Cecil Md.			
21. I certify that (I) (this hospital) attended the deceased from 1/26 , 19 62 , to 3/28 , 19 62 , that (II) (we) last saw the deceased alive on 3/28 , 19 62 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.				22a. SIGNATURE Joseph G. Lanzi M.D. 3/28/62 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Joseph G. Lanzi 22d. ADDRESS 205 W. Main St. Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/31/62 23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery 23d. LOCATION (City, town or county) (State) Cherry Hill, Md.				24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md. 25a. REC'D BY REGISTRAR APR 19 '62 25b. REGISTRAR'S SIGNATURE Arthur E. Hanna			

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Item 20 Fill in 312 5-3-62
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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2-002108

1935

STATE OF NEW YORK

1935

County of

City of

County of

City of

City of

Union Hospital

John J. [illegible]

March 28

Jan. 22, 1935

Female

Maryland

Walter H. Butler

Lawrence H. Butler

Walter H. Butler, Union, N.Y.

George

George

March 28

March 28

March 28, Union, N.Y.

Joseph A. [illegible]

George H. [illegible]

March 28

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03087

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Conowingo, Md		c. LENGTH OF STAY IN b Native of Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Geo. G. Meade, U.S. Army Camp Brunswick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 1 & 222 at North end of Dam		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Day Year 3 24 19 62		5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18 1941		9. AGE (in years last birthday) yrs. 21		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Joseph Daniel Clark		14. MOTHER'S MAIDEN NAME No information		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 6-12-59 to 3-24-62 219-34-5595	
16. SOCIAL SECURITY NO. 6-12-59 to 3-24-62 219-34-5595		17. INFORMANT Capt. Frederic L. Mundy, Co. Hq. & Hq. Co. USAGO		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound comminuted fracture, right 2 823 X DUE TO left parietal bones with destruction of Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) underlying meningitis and brain tissue DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 1 & 222 Conowingo Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 3-28-62		22c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery, Perryville, Md.		22d. LOCATION (City, town, or country) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR Lee C. Patterson & Son		24a. REC'D BY REGISTRAR DATE MAR 28 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25. CHIEF MEDICAL EXAMINER R. C. Dodson MD		26. ASSISTANT MEDICAL EXAMINER DATE SIGNED 3-24-62	

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To Eng. Division of 333 - I. 38

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File # 61-1002



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03097

CERTIFICATE OF DEATH

Reg. Dist. No. 03088

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | | | c. LENGTH OF STAY IN 1b <u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>243 East High Street</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Jacob Congo</u> | | | | 4. DATE OF DEATH <u>March 5th, 1962</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 7, 1932</u> | |
| 9. AGE (In years last birthday) <u>29</u> yrs. | | IF UNDER 1 YEAR <u>4</u> Months <u>26</u> Days | | IF UNDER 24 HRS. <u>26</u> Hours <u>0</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>James Congo</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Brooks</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Korean</u> | | | | 16. SOCIAL SECURITY NO. <u>215-28-7763</u> | | | |
| 17. INFORMANT <u>Anna Congo-243 High St., Elkton, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Dilatation of Heart</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u>
DUE TO
(c) <u>Pulmonary Edema</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Edema 3- Years</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>1-Day</u>
<u>3- Years</u>
<u>2- Days</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>9/28/1955</u> , to <u>3/5/1962</u> that I last saw the deceased alive on <u>3/3/1962</u> , and that death occurred at <u>4:00 M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James L. Johnson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>245 East High Street</u> DATE SIGNED <u>3/5/62</u> | | | |
| PHYSICIAN'S NAME (Type) <u>James L. Johnson M.D.</u> | | | | <u>Elkton Cecil Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/8/62</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Griffith Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cedar Hill, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. E. Bell</u> ADDRESS <u>909 Poplar St.</u> | | | | 24a. REC'D BY REGISTRAR <u>MAR 9 '62</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u> | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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03098

CERTIFICATE OF DEATH

Reg. Dist. No. 03089

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY CECIL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY CECIL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CALVERT | | | | c. LENGTH OF STAY IN 1b
5-YRS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
GRAYBEALS NURSING HOME | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) IDA First M Middle CONLYN Last | | | | 4. DATE OF DEATH MARCH Month 28 Day 1962 Year | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 27, 1864 | |
| 9. AGE (In years lost birthday) 97 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE-WIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
WILMINGTON, DEL. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
SAMUEL SHUSTER | | | | 14. MOTHER'S MAIDEN NAME
MARGARET KEELY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. NONE | | | |
| 17. INFORMANT MRS ELEANOR RACINE, NORTH EAST, MD. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 10 19 61 to 3/28 19 62 that I lost saw the deceased olive on 3/28 19 62 and that death occurred at 11A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 3/29/62 | | | | | | | |
| ACTUAL SIGNATURE Neil Taylor | | | | PHYSICIAN'S NAME (Type) Neil Taylor, Rising Sun, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
4/2/1962 | | 22c. NAME OF CEMETERY OR CREMATORY
ST. JAMES CEMETARY NEWPORT, DELAWARE | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ralph M Reed, Rising Sun, Md. | | | | 24a. REC'D BY REGISTRAR
PR 2 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

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MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03099

CERTIFICATE OF DEATH

03090

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|--|----------------------------------|--|------------------------------------|---|---|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Perryville | | c. LENGTH OF STAY IN 1b
Life | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Perryville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Susquehanna Ave. | | | | d. STREET ADDRESS
Susquehanna Ave. | | | |
| 3. NAME OF DECEASED (Type or print)
First Willis Middle Marshall Last Gillespie | | | | 4. DATE OF DEATH Month March Day 22 Year 19 62 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/15/97 | | 9. AGE (In years last birthday)
64 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Railroad Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland, Cecil Co. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Joseph Gillespie | | | | 14. MOTHER'S MAIDEN NAME
Effie Boulden | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW-1 | | 16. SOCIAL SECURITY NO.
716-12-3079 | | 17. INFORMANT
Helen C. Gillespie, Perryville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of lung, right
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO
(b) (c) | | | | INTERVAL BETWEEN ONSET AND DEATH
8 MONTHS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not White <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-15 , 19 62 , to 3-22 , 19 62 , that (I) (we) last saw the deceased alive on 3-22 , 19 62 , and that death occurred at 3AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John D. Yun | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3-22-62 | |
| 22c. PHYSICIAN'S NAME (Type)
John D. Yun | | | | 22d. ADDRESS
Perryville, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Mar. 25, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY
Asbury Cemetery | | 23d. LOCATION (City, town or county) (State)
RFD, Port Deposit, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lee A. Patterson & Son | | | | ADDRESS
Perryville, Maryland | | 25e. REC'D BY REGISTRAR
Mar 27 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03100

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

04448

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>
c. LENGTH OF STAY in lb <u>10 Days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>21 EIKTON</u>
d. STREET ADDRESS <u>116 Hollingsworth Manor</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>David F. Hollingsworth</u> | | 4. DATE <u>DEATH</u> <u>MARCH 18</u> 19 <u>62</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 9, 1903</u> 58 yrs. |
| 9. AGE (in years last birthday) <u>58</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Chester Co, Penna.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>David F. Hollingsworth, Sr.</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Pyle</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>ANN MARIE Hollingsworth</u> Address <u>—</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u>
<u>443X</u> DUE TO <u>with congestive heart failure</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>—</u>
DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Lacunar cirrhosis with ascites</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>60</u> to <u>March 18</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> 19 <u>62</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Tillman D. Johnson</u> M.D. | | 22b. DATE SIGNED <u>3-21-62</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson MD</u> | | 22d. ADDRESS <u>123 Singsley Ave. EIKTON Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>3/22/62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Union Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Kennett Square, Penna.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>EIKTON, Md.</u> | | 25a. REC'D BY REGISTRAR <u>APR 19 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03091

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| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Earlville | | | | c. LENGTH OF STAY IN 1b
all life | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS
Earville | | | |
| 3. NAME OF DECEASED
(Type or print)
First Wesley Middle John Last Husfelt | | | | 4. DATE OF DEATH
Month 3 Day 31 Year 19 62 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-11-1889 | | 9. AGE (in years last birthday)
73 yrs. | IF UNDER 1 YEAR
Months 3 Days 31 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farming Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Husfelt | | | | 14. MOTHER'S MAIDEN NAME
No information | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
no | | 16. SOCIAL SECURITY NO.
220-07-6899 | | 17. INFORMANT
Sis Feas Charlestown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion acute
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 minutes | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
R.C. Dodson | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
R.C. Dodson | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Rising Sun md. (county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
April, 4, 1962 | | 22c. NAME OF CEMETERY OR CREMATORY
Johnstown Cemetery | | 22d. LOCATION (City, town, or country) (State)
Earlville, Rural. Md. | |
| 23. FUNERAL DIRECTOR
Edward Fellows, Mellington, Md. | | | | 24a. REC'D BY REGISTRAR
APR 5 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Haines | |

MEDICAL CERTIFICATION

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03102

CERTIFICATE OF DEATH

03092

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Galena 14X-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Union Hospital | | d. STREET ADDRESS
Galena | |
| 3. NAME OF DECEASED (Type or print)
First Philip Middle Bernard Last Ireland | | 4. DATE OF DEATH
Month March Day 31 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 27, 1882 |
| 9. AGE (In years last birthday) 79 yrs. | | 10. AGE (In years last birthday) 79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm Labor | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Galena, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph P. Ireland. | | 14. MOTHER'S MAIDEN NAME
Elizabeth Kennard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
214-34-6024 | |
| 17. INFORMANT
Mrs. Frances Gillespie, | | Address
Galena, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism massive
DUE TO (b) plebothrombosis rt leg.
DUE TO (c) Carcinoma of rt kidney with regional metastases.
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 180 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Senility urethral stricture | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Mar 26 19 62 to Mar 31 19 62 , that (I) (we) last saw the deceased alive on mar 31 19 62 , and that death occurred at 12:40 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wallace Obenshain | | 22b. DATE SIGNED
2 Apr 62 | |
| 22c. PHYSICIAN'S NAME (Type)
Wallace Obenshain, M.D. | | 22d. ADDRESS
Cecilton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
April, 3, 1962 | 23c. NAME OF CEMETERY OR CREMATORY
Methodist Church Yard, | 23d. LOCATION (City, town or county) (State)
Galena, Kent Co; Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Edward Fellows, Mellington Md. | | 25a. REC'D BY REGISTRAR
APR 4 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

080032

07132



TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03093

03103

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. LENGTH OF STAY IN 1b
9 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Union Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HOWARD Middle B. Last ISAACS | | 4. DATE OF DEATH
Month 3-24 Day 1962 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-25-1910 |
| 9. AGE (In years last birthday)
51 yrs. | | 10. IF UNDER 1 YEAR 11 Months 30 Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer Trackman | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O R.R. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Martin Isaacs | | 14. MOTHER'S MAIDEN NAME
Jane Biddle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
705-09-7352 | |
| 17. INFORMANT
Mrs Dorothy Honaker Port Deposit R.D. Md | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Vascular Failure
420-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombotic Occlusion left coronary art.
DUE TO (c) Myocardial infarction | | INTERVAL BETWEEN ONSET AND DEATH
5 min.
10 min.
10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Sclerotic al coronary arteries. G.A.S., A.S.H.D. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-15-1962 to 3-24-1962 that I last saw the deceased alive on 3-23-62 and that death occurred at 1.10P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cecil Ave. North East, Md. DATE SIGNED 3-26-62
ACTUAL SIGNATURE Luis M. Cuza M.D.
PHYSICIAN'S NAME (Type) Luis M. Cuza | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3-27-1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Ebenezer | | 22d. LOCATION (City, town, or county) (State)
Rising Sun Rural, Cecil, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph R. Grant | | ADDRESS
North East, Maryland | |
| 24a. REC'D BY REGISTRAR
MAR 28 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | |

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CERTIFICATE OF

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03104
CERTIFICATE OF DEATH
03094

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>
c. LENGTH OF STAY IN 1b <u>12 hours</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North East</u>
d. STREET ADDRESS <u>1</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Baby</u> Middle <u>Johnson</u> Last <u>Johnson</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>2</u> Year <u>1962</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 1962</u> | |
| 9. AGE (In years last birthday) <u>12</u> | | IF UNDER 1 YEAR
Months <u>12</u> Days <u>12</u> | | IF UNDER 24 HRS.
Hours <u>12</u> Min. <u>12</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Cecil County Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Corbin Johnson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Modenna Lewis</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Mother</u>
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>762.5</u> DUE TO <u>Respiratory Failure (atelectasis) prematurely</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>62</u> to <u>3/2</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2 Am</u> 19 <u>62</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>James L. Johnson</u>
22c. PHYSICIAN'S NAME (Type) <u>JAMES L. JOHNSON</u> | | | | M.D.
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <u>245 E. High St, Elkton, Md.</u> | | 22b. DATE SIGNED <u>3/2/62</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3-3-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u> | | 23d. LOCATION (City, town or county) (State) <u>Northeast Cecil Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Joseph R Grant</u> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 5 '62</u> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles S. Kraus</u> | |

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STATE OF NEW YORK

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County of Albany

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Five hundred

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for the

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

13
03105
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03095
CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Perry Point
c. LENGTH OF STAY IN b
60 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
D.C.
b. COUNTY
Washington, D. C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47X-3
d. STREET ADDRESS
118 46th St. S. E.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
HENRY EUGENE JOHNSON | | 4. DATE OF DEATH
March 4, 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-12-13 |
| 9. AGE (In years last birthday)
48 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Messenger | | 11. BIRTHPLACE (County & State, or foreign country)
Vandalia, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Ed Johnson | |
| 14. MOTHER'S MAIDEN NAME
Orpha King | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW II | |
| 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
VA Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
177X DUE TO Carcinoma Of Prostate With Metastases.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Uremia | | INTERVAL BETWEEN ONSET AND DEATH
2 To 3 Mon. | |
| 20a. UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
Uremia | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 3, 1962 to March 4, 1962 , and that death occurred at 12:25 AM on the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Bernard S. Linn | | 22b. DATE SIGNED
3/4/62 | |
| 22c. PHYSICIAN'S NAME (Type)
BERNARD S. LINN, M.D. | | 22d. ADDRESS
VA HOSPITAL, PERRY POINT, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Buried | | 23b. DATE THEREOF
3-9-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
arlington cemetery | | 23d. LOCATION (City, town or county) (State)
arlington va | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Montgomery Brod | | 25a. RECEIVED BY REGISTRAR
39-62 | |
| 25b. REGISTRAR'S SIGNATURE
L. B. Montgomery No 54 | | MAR 14 '62 | |



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Party Point

60 Days

Washington, D. C.

Veteran Administration Hospital

118 16th St. S. E.

HENRY

JOHN

JOHNSON

JOHN

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5-12-13

18

VA Office

Vandalia, Missouri

Other King

Ed Johnson

Unknown

VA Records, VAM, Fort Point, Mo.

Yes

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Continued on front of this page

Inmate

X

January 3

12:25 PM

12:25 PM

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RECEIVED 11/11/13

3d-02 of 24

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03106
CERTIFICATE OF DEATH
03096

| | | | | | |
|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Cecil</u> <u>MARYLAND</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton</u>
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton</u> <u>RD #5</u>
d. STREET ADDRESS <u>1</u>
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) <u>HARVEY</u> <u>L.</u> <u>LEEDON</u> | | | 4. DATE OF DEATH
Month <u>Mar.</u> Day <u>22</u> Year <u>19 62</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 16, 1886</u> | 9. AGE (In years last birthday) <u>75</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Millwright</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Steel</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Charlestown, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 13. FATHER'S NAME
<u>Levi L. Leedom</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Carrie Boyd</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>No</u> | | |
| 16. SOCIAL SECURITY NO.
<u>221-01-8871</u> | | | 17. INFORMANT
<u>MRS. HARVEY L. LEEDON</u> Address <u>RD #5 ELKTON, MD.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
<u>4-20-0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(a), stating the underlying cause last. DUE TO (c) <u> </u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-4-1962</u> to <u>3-22-1962</u> that (I) (we) last saw the deceased alive on <u>3-5-1962</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>William D. Johnson</u> M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3-22-62</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>William D. Johnson</u> | | | 22d. ADDRESS
<u>123 S. 1st Ave. Elkton, Md.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3-26-62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Silverbrook Cem.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Wilmington, Del.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>PIPPIN FUNERAL HOME</u> | | | ADDRESS
<u>Donald B. Pippin</u> | | 25a. REC'D BY REGISTRAR
<u>DATE MAR 27 '62</u> |
| | | | 25b. REGISTRAR'S SIGNATURE
<u>William S. Thomas</u> | | |

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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03107

CERTIFICATE OF DEATH

Reg. Dist. No.

03097

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cecilton Rural X | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Union Hospital | | d. STREET ADDRESS
1 | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Isabel Middle Clark Last Manlove | | 4. DATE OF DEATH
Month March Day 27 Year 1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 8, 1897 |
| 9. AGE (In years last birthday)
64 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Thomas Clark | | 14. MOTHER'S MAIDEN NAME
Laura Ellen Veach | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
None | |
| INFORMANT
Miss, Emily M. Manlove, Cecilton, Md. Rural | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LEFT HEMIPLEGIA
DUE TO 331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CEREBRAL HEMORRHAGE
DUE TO
(c) CEREBRAL ARTERIO SCLEROSIS
INTERVAL BETWEEN ONSET AND DEATH
3 DAYS
3 DAYS
1 YEAR | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 2, 1962 to March 27, 1962 that I last saw the deceased alive on MARCH 27, 1962 and that death occurred on 11/25 PM M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD DATE SIGNED 3/28/62 | | | |
| ACTUAL SIGNATURE Henry V. Davis M.D. | | | |
| PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Mar. 30, 1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY
St. Stephen's Cemetery. | | 22d. LOCATION (City, town, or county) (State)
Earleville, Rural. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Edmond V. Brown Cecilton Md. | | 24a. REC'D BY REGISTRAR
APR 2 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Charles S. Thomas | | | |

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CERTIFICATE OF DEATH

10100

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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03108

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03098

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point
c. LENGTH OF STAY IN 1b 25yrs8mos19days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Pennsylvania b. COUNTY Chester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkesburg
d. STREET ADDRESS none
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First FRANK Middle MILLER Last MILLER | | | | 4. DATE OF DEATH
Month March Day 9 Year 19 62 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 28, 1892 | |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR
Months 69 Days 69 | | IF UNDER 24 HRS.
Hours 69 Min. 69 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (County & State, or foreign country) Dauphin County, Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Jacob Miller | | | | 14. MOTHER'S MAIDEN NAME Rose (?) Miller | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-1 | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Coronary Occlusion
(a), stating the underlying cause last. DUE TO (c) Arteriosclerotic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 Day
1 Day
Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. VA 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XXXXXX attended the deceased from June 18, 1936 , to March 9, 1962 XXXXXX and that death occurred at 5:30PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE A.L. Mooney M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 3-9-62 | |
| 22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, M.D. Asst.Path. | | | | 22d. ADDRESS VAH, Perry Point, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-14-62 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE MAR 16 '62 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna | | | |

(M)

1011

Barry Jones

Styrene Monomer

Parkburg

Veterans Administration Hospital

none

FRANK

MINNIE

LEON

x

x

White

Male

July 28, 1942

69

Belmont

Washington County, Penn.

628

Jacob Miller

Rose (A) Miller

10-1

Unknown

Hospital Records, VA Hospital, Perry Point, Md.

Acute primary disease

Secondary infection

Antibiotic-resistant strain

diagnosis following

XXXXXX

XXXXXXXXXXXXXXXXXXXX

June 18, 42

12:30 PM

6-1-42

6-1-42

A. L. MOORE, M.D., Asst. Dir., V.A. Hosp., Perry Point, Md.

Belmont - Washington

Belmont, Md.

Belmont, Md., State of Ohio, M.D.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03109

03099

| | | | | | |
|---|---------------------------|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montgomery ✓ | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Perry Point | | | c. LENGTH OF STAY in 1b
28Yrs.8 mo. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | d. STREET ADDRESS
10110 Georgia Avenue | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
HARRY WEBSTER MULLEN | | | 4. DATE OF DEATH
Month Day Year
March 7 19 62 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-16-87 | 9. AGE (In years last birthday)
74 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
Wallace A. Mullen (deceased) | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 14. MOTHER'S MAIDEN NAME
Ida Harper (deceased) | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW-I | | |
| 16. SOCIAL SECURITY NO.
----- | | | 17. INFORMANT
Hospital Records, VAH, Perry Point, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infarction of brain (cerebral vascular accident) 3-4 weeks
332X } DUE TO (b) Cerebral thrombosis due to arteriosclerosis 3-4 weeks
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Emphysema | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
VA 19 | | 20d. INJURY OCCURRED
While Not While
el work <input type="checkbox"/> el work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that XXXXXX attended the deceased from June 21, 1933 to March 7, 1962 XXXXXX
and that death occurred 12:15 am M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
A. L. Mooney M.D. | | | 22b. DATE SIGNED
3-8-62 | | |
| 22c. PHYSICIAN'S NAME (Type)
A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | | | 22d. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
3/12/62 | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 23d. LOCATION (City, town or county)
Arlington, Virginia | | 23e. (State) | | 23f. (Country) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Donington & Son, Harry de Grace, Md. | | | 25a. REC'D BY REGISTRAR
DATE MAR 16 '62 | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Pines | | | 25c. (Signature) | | |

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03099

1973

Country: Maryland
Address: 1110 Beardsley Avenue
City: Baltimore
State: MD
Zip: 21201
Name: Wallace A. Miller (deceased)
Date of Birth: 1-15-27
Date of Death: 7-4-73
Cause of Death: Unknown

Yes
Hospital records, FBI, Perry Point, Md.
Information of death (cerebral vascular accident) - 2 weeks
Cerebral thrombosis due to arteriosclerosis - 2 weeks
Immunization

June 21 1973
12:15 PM
A. J. GUNY, M.D., Pathologist, VAMC, Perry Point, Md.
Washington National
Washington, D.C. 20546

1 **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|-------------------------------|--|---------------------------------------|---|--|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural North East | | d. STREET ADDRESS 1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Garrett Oldis | | | | 4. DATE OF DEATH Month March Day 30 Year 19 62 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 17, 1871 | | 9. AGE (In years last birthday) 2 90rs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman - Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY B & O R.R. Ret. | | 11. BIRTHPLACE (County & State, or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? USS | |
| 13. FATHER'S NAME Benjamin Oldis | | | | 14. MOTHER'S MAIDEN NAME Cornelia | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Cecil County Welfare records Address Elkton, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular Failure
420.0 DUE TO (b) Cardiac Decompensation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) A. S. H. D.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) G. A. S., Hypertension | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min
1 wk
Years. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 2Dc. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 2Df. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-29-1962 to 3-30-1962 that (I) (we) last saw the deceased alive on 3-29-1962 and that death occurred 6:30 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Luis M. Cuza | | | | M.D. Luís M. Cuza | | 22b. DATE SIGNED April 2-1962 | |
| 22c. PHYSICIAN'S NAME (Type) Luis M. Cuza | | | | 22d. ADDRESS Cecil Ave. North East, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-2-1962 | | 23c. NAME OF CEMETERY OR CREMATORY Bay View Methodist | | 23d. LOCATION (City, town or county) (State) North East R.D. Cecil Co., Md | |
| 24 FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland | | | | 25a. REC'D BY REGISTRAR APR 3 '62 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 23a & b, Film Q310 4/4/62 iwk

| | | | | | | |
|---|----------------------------------|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Point,
c. LENGTH OF STAY IN 1b
1 month 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bradshaw
d. STREET ADDRESS
Reynolds Road
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First
OSCAR
Middle
FRANK
Last
RAY | | 4. DATE OF DEATH
Month
March
Day
31,
Year
19 62 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 22, 1889 | 9. AGE (In years last birthday)
72 yrs. | IF UNDER 1 YEAR
Months
03 Days
x 2 | IF UNDER 24 HRS.
Hours
00 Min.
00 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter-retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Painting | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore County, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Frank Ray | | 14. MOTHER'S MAIDEN NAME
Lilly Jordan | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW-I | | 16. SOCIAL SECURITY NO.
220 20 7466 | | 17. INFORMANT
Address
Hospital Records, VAH., Perry Point, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia w/cavitation, rt lower & middle Lobe.
527. } DUE TO
Conditions, if any, which gave rise to immediate cause (b) Emphysema, bilateral, severe
(c) Unknown
(e), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis, generalized, moderately severe. | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour e.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) |
| 21. I certify that (I) (this hospital) attended the deceased from February 9, 1962 to March 31, 1962 that (I) (we) last saw the deceased alive on March 31, 1962 , and that death occurred at 8:AM , from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE
J. L. Garey
M.D.
22c. PHYSICIAN'S NAME (Type)
J. L. GAREY, M.D.
Clinical Pathologist | | ATTENDING PHYS.
<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS
VAH., Perry Point, Maryland | | 22b. DATE SIGNED
3-31-62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE THEREOF
3-31-62 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Christian Church | | 23d. LOCATION (City, town or county)
(State)
Joppa, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
LASSAHN FUNERAL HOME, | | ADDRESS
7401 Belair Rd., Baltimore 6, Md. | | 25a. REC'D BY REGISTRAR
DATE APR 4 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur E. Kinner |

03101

Baltimore

Harland

Genl

Bracewell

I month 22 days

Perry Point

Reynolds Road

Veterans Administration Hospital

RAY

FRANK

OSCAR

December 22, 1982

White

Baltimore County, Md.

Painting

Painter-qualified

Elly Jordan

Frank Ray

Wash., Perry Point, Md.

220 30 4500

W-1

Yes

Lower Paronychia w/ onycholysis, the lower 6 middle
toes. 8 - 10 days

Onychomycosis, bilateral, severe

Onychomycosis, generalized, moderately severe.

February 2, 83
March 21, 83

March 21, 83

1-21-83

Wash., Perry Point, Maryland

J. L. GARY, M.D.
Clinical Pathologist

107th, Maryland

St. Christian Church

1-21-83

Removal

W. L. Bell, Jr.
Baltimore, Md.

BARBARA KUMAR, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

03112
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03102
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rising Sun, Rural | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Deposit Rural | | |
| 3. NAME OF DECEASED
(Type or print)
First Timothy Middle Roger Last Stroud | | | 4. DATE OF DEATH
Month 3/ Day 13/ Year 19 62 | | |
| 5. SEX M. 6. COLOR OR RACE W. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 1/2/1962 9. AGE (In years last birthday) 2 yrs. 10. IF UNDER 1 YEAR Months 2 Days 10 11. IF UNDER 24 HRS. Hours 10 Min. | | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Roger C. Stroud Address Port Deposit Md. R.D. 1 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Compound, comminuted fracture, left parietal and temporal bones with extensive damage to and loss of brain tissue
DUE TO Immediare
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO Immediare
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Auto Accident | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour 6:40 p.m. Month, Day, Year 3-13-62 19 62 | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 273 20f. (City or town) Cecil Co. Md. (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE R. C. Dodson
EXAMINER'S NAME (Type) R. C. DODSON | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 3/15/62 22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem. 22d. LOCATION (City, town, or country) Rising Sun, Md. (State) | | |
| 23. FUNERAL DIRECTOR Edmond E. McMiller | | | 24a. REC'D BY REGISTRAR MAR 16 '62 24b. REGISTRAR'S SIGNATURE Charles S. Thomas | | |

21 83

(M)

Miss Susan, Kansas

Tom Depoe

Cecil

Harri

Timothy

Homer

Second

1/2/1900

M.

W.

None

None

Virginia

Unknown

U.S.A.

Foster Foster Robert O. Second

Robert O. Second

No

Port Depoe M.

Gifts Received

1900-1901

E. O. Bodger

Miss Susan, M.

Harri West Nottingham Cem. Colo. M.

Miss Susan, M.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
031113 CERTIFICATE OF DEATH 03103

| | | | |
|--|------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE North Carolina b. COUNTY | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charlotte | |
| c. LENGTH OF STAY IN b. 14yrs.5mo.21days | | d. STREET ADDRESS 135 1/2 S. Tyron | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ALICE L. SULLIVAN | | 4. DATE OF DEATH March 31 19 62 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-31-88 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Private | 11. BIRTHPLACE (County & State, or foreign country) Massachusetts |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edward F. Sullivan (deceased) | |
| 14. MOTHER'S MAIDEN NAME Ellen (?) Sullivan (deceased) | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, bilateral
DUE TO (b) Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis generalized | | INTERVAL BETWEEN ONSET AND DEATH 7-10 days
unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XXXXXX attended the deceased from October 10, 1947, to March 31, 1962, and that death occurred at 9:30 am from the causes and on the date stated above. | | | |
| 22a. SIGNATURE A. L. Mooney M.D. | | 22b. DATE SIGNED 4-2-62 | |
| 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE THEREOF 4/4/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son | | 25a. REC'D BY REGISTRAR APR 5 62 | |
| ADDRESS Havre de Grace, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

07103

CERTIFICATE OF DEATH

2118

North Carolina

Death

Charlotte

Ferry Point

1978 2 17th

at the Washington Hospital

31

SHAWAN

1102

73

12-1-88

White

Female

USA

Unemployed

Private

Home

Edward P. Sullivan (husband) Ellen (.) Sullivan (daughter)

Yes M-1 Home Hospital Records, Van, Ferry Point, VA

Resonance, bilateral

the rheumatic heart disease

myocardial pain generalized

October 10 47

2:30

1-12

A. M. WOODRUFF, M.D., Clinical Director, Van, Ferry Point, VA

Witnessed by: [Signature]

Signature of [Name] [Title]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03114

03104

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Cecil | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rural North East | | | | c. LENGTH OF STAY IN 1b
16 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS
1 | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Carl Victor Wennberg | | | | 4. DATE OF DEATH
Month Day Year
March 12 1962 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 5, 1885 | |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country)
Stockholm, Sweden | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
---- Wennberg | | | | 14. MOTHER'S MAIDEN NAME
Anna (no information) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
097-05-7805 | | 17. INFORMANT Address
Mrs. Esther M. Wennberg, North East R.D., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Coronary thrombosis
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) arteriosclerotic heart disease
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
8 Hour e.m. 3 12.62
p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
North East Cecil Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type)
Joseph R. Grant | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED
3/12/62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | | 22b. DATE THEREOF
3-15-62 | | 22c. NAME OF CEMETERY OR CREMATORY
Silverbrook | |
| 23. FUNERAL DIRECTOR
Joseph R. Grant | | | | 22d. LOCATION (City, town, or country) (State)
New Castle Wilmington, Delaware | | 24a. REC'D BY REGISTRAR
DATE MAR 15 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Francis | | | | | | | |

North East, Md.

00101

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

00101

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY



TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal report or memorandum.]